TotalCare℠ HMO D-SNP

Information Release: Member's Authorization to Disclose Protected Health Information

To allow Central California Alliance for Health to release or disclose your medical information, you must first give your authorization.

Member Information

Name: _____

Address: _____

Telephone: _____

Member ID Number: _____

Date of Birth: _____

Purpose of Request

Please describe why the information is being requested:

☐ Personal Use ☐ Insurance ☐ Legal

☐ Medical Treatment ☐ Other: _____

Health Information may be released to the following:

Name/Agency: _____

Address: _____

Telephone: _____

Fax: _____

☐ **Check if giving permission to speak to multiple persons or agencies (if checked, complete Authorized Persons/Agencies part on page 3)**

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Information to be Disclosed

☐ All records related to care

☐ Claims History

☐ Case Management or Medical Management Records

☐ Enrollment History

☐ Other *(please describe):*

Date Range (*optional):* From _____ To _____

Sensitive Information (Requires Specific Authorization and Signature)

Please check and sign for any category you authorize to release:

☐ **Alcohol/Drug Treatment**

Signature:_____

☐ **Mental Health Information**

Signature:_____

☐ **HIV-Related Information**

Signature:_____

☐ **Genetic Test Results**

Signature:_____

☐ **Psychotherapy Notes**

Signature:_____

Authorization Expiration

This authorization to disclose sensitive information expires (choose one):

☐ 1 year from the date signed

☐ On this date: _____

☐ Upon the following event: _____

Important Information – Please Read

- **No Conditions:** You do not have to sign this form. If you decide not to sign this authorization, it will not affect enrollment in our health plan or your eligibility for health benefits.
- **Right to Revoke:** You may revoke this authorization at any time in writing to the Alliance's Privacy Official. Revocation will not apply to actions already taken.
- **Disclosure Risks:** Information disclosed may be re-disclosed by the recipient and may no longer be protected under federal privacy law (HIPAA).

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- **Your Rights:** You are entitled to a copy of this authorization.
- **No Conditions:** You do not have to sign this form. If you decide not to sign this authorization, it will not affect enrollment in our health plan or your eligibility for health benefits.

Member Signature

I have read and understand this form. I authorize the Alliance to release the specified protected health information for the purposes stated.

Signature of Member: _____ **Date:** _____

If Signed by Personal Representative

Personal Representative Name: _____

Relationship to Member: _____

Signature of Personal Representative: _____

Where to Send this Form

Mail this completed form to:
Central California Alliance for Health
Attn: Compliance Department
1600 Green Hills Rd. Ste. 101
Scotts Valley, CA 95066

Authorized Persons/Agencies Continued

Health Information may be released to the following:

Name/Agency: _____

Address: _____

Telephone: _____

Name/Agency: _____

Address: _____

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Name/Agency: _____

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Purpose of the Authorization Request: